Cost Avoidance

Suggestions

And

Helpful Hints

Draft

Revised

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Cost Avoidance Suggestions and Hints Draft October 2008

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Quick Overview

Sections:

Quick Overview

HRSA is required by federal regulation to determine the liability of third-party resources available to HRSA clients. All resources available to the client that are applicable to costs of medical care must be used. Once the applicable resources are applied, HRSA may make reimbursement on the balance if the insurance payment is less than HRSA's allowed amount.

It is the provider's responsibility [WAC 388-501-0200] to bill HRSA appropriately after pursuing any potentially liable third-party resource when:

1. Health insurance is indicated on the Medical ID Card.
2. The provider's HRSA billing site alerts the provider to a client's insurance; or
3. The provider believes insurance is available

The insurance carrier list and carrier information is available. The information can be downloaded and printed or used as an online reference. (see section 2).

HRSA's billing time limit is 365 days, but an insurance carrier's time limit to bill may be different. It is the provider's responsibility to meet the insurance carrier's billing time limit prior to receiving any payment by HRSA.

The provider's weekly Remittance and Status Report (RA) may show the claim as denied with the Explanation of Benefits (EOB) 0090. The EOB states "Please bill your claim to the insurance company as instructed. For questions call 800.562.6136." The insurance carrier information is printed on the RA for the provider's reference. Please call Coordination of Benefits with insurance issues.

Client's with last names beginning with A through G:
Call 1-800-562-6136 and ask to speak with nursing home case manager

Client's with last names beginning with H through Z:
Call 1-800-562-6136 and ask to speak with nursing home case manager

Fax: 360-586-3005

Denials/questions not related to private insurance; change in participation, class, days, award letter, Medicare advantage plans, etc. please direct your calls to the appropriate contact person in the Nursing Home Claims processing unit. If in doubt as to whether your claim was denied for private insurance, please refer to your RA denial reason code explanation at the end of your HRSA RA.

Quick Overview

Nursing Home Claims processing unit **contacts are by the first letter of the name of Skilled Nursing Facility**. (see listing below)

Caseload Managers in Nursing Home Claims processing unit:

A-C 360-725-1860

D-G 360-725-1081

H-L 360-725-1052

M-O 360-725-1089

Q-Z 360-725-1054

P 360-725-1051

S 360-725-1158

Denials Related to Insurance are:

0032 – this insurance payment exceeds the DSHS allowable fee.
0090 – this care may be covered by another payer per COB. System generated denial, claim is not seen by case manager. Please provide insurance payment/denial or complete section 8 and fax denial or section 8 along with a comment to the appropriate case manager.
0281 – The backup documents/comments are inappropriate or lacking information. Please rebill with the appropriate information
0287 – The EOB/comment was from an incorrect insurance carrier. Please rebill with correct EOB/comment
0288 – More than one insurance carrier is available. Please submit EOB backup/comment from each carrier.
0981 – Not a valid insurance denial

Frequent Questions:

1. How do I find out if a client has private insurance?

Ask the client/family if there is insurance coverage, an insurance card, and/or Medical ID Card (MAID).

2. When I bill HRSA my claim rejects to bill the private insurance?

Quick Overview

Private insurance information is updated daily: The insurance information prints out on the HRSA remittance advice for your convenience.

3. How would I recognize a Health Maintenance Organization (HMO)?

A client with privately purchased Health Maintenance Organization (HMO) insurance will have a HI, HM, HO identifier in the insurance column on their MAID. The client is required to use a HMO facility. Situations may occur when a client is out of the HMO service area or there is no HMO facility available in the service area. (see section 13 ADSA questions 30 and 31 and HCS Good Cause policy).

4. What do I do if a client's insurance coverage requires a Medicare denial or other information?

The Skilled Nursing Facility must meet all third-party billing requirements.

5. How do I bill if the insurance carrier requires authorization or certification?

The primary insurance carrier requirements must be met. Contact the insurance carrier for authorization/certification review to determine if the room and board is covered by the insurance plan.

6. The client has insurance coverage through multiple carriers. Am I required to bill all potential payers?

Yes. It is the provider's responsibility to seek timely reimbursement from a third-party when a client has available third-party resources. [WAC 388-501-0200]

Important Telephone Numbers:

1. Aging and Disability Services Administration 1-800-422-3263
2. Office of Financial Recovery 1-800-562-6114

Section 1

Cost Avoidance **Suggestions**

1. ALWAYS bill Medicaid.

2. ALWAYS bill the insurance and Medicare immediately.

3. ALWAYS fax a copy of the insurance Explanation of Benefits (EOB) **or** a copy of your letter concerning your conversation with the insurance company (see Section 8) and your proposed comment to: 360-586-3005 Attn: (nursing home case manager).

4. ALWAYS check the coupon/medical ID card (MAID) for insurance. .

5. ALWAYS ask the client/family for a copy (front and back) of all insurance cards. The card contains important identification numbers, billing addresses and telephone numbers.

6. ALWAYS ask the client/family to get a copy of the policy. The policy will clarify the Skilled Nursing Facility (SNF) benefits and what is required to receive those benefits.

7. CONFIRM with the client/family that they know when to start turning the insurance check over to the Nursing Home. If a new release form is needed for reassignment of benefits, have the client/family contact the insurance company for a new release form.

8. ALWAYS follow the pre-cert/pre-auth/referral process.

9. ALWAYS bill your private rate. The insurance is primary to Medicaid

10. ALWAYS do timely follow-up with the insurance company

11. ALWAYS call the insurance company if you do not understand their denial reason.

12. ALWAYS restart the insurance billing process when there is a change of circumstance in the client's care.

13. BE PREPARED to refund the participation and report that refund to the Home and Community Service Office (see Section 10).

14. BE PREPARED to re-verify insurance coverage, policies can be renegotiated every year. Fax a copy of that verification to: 360-586-3005
    Attn: Nursing Home case manager

Section 2

Cost Avoidance **Important Sources of Information**

1. http://fortress.wa.gov/dshs/maa/ click on Billing Instructions and Numbered Memorandum, click on ACCEPT, click on Billing Instructions, click on G (for General Information Booklet, or N for Nursing Facility Billing Instructions), scroll until you have the heading you want, click on the heading. That will bring up your request. Click on request to open:

    A. **General Information Booklet** found under Billing Instructions/numbered Memorandum. This booklet is full of general information on billing, rebilling and adjusting your claims. Excellent resource.
    B. **Nursing Facility Billing Instructions** found under Billing Instructions/numbered memorandum. This is the Aging and Adult Services and Health Recovery Services Administration manual for billing Nursing Facility claims to Medicaid.
    C. **Numbered Memos** are found under Billing Instructions/numbered memorandum. These are updates to be added to your Nursing Facility Billing Instructions.

2. https://wamedweb.acs-inc.com/wa/secure.home.do

    A. **WAMedWeB Home** contains client specific insurance information. Under site contents – under inquires: click on eligibility inquires. Type in the PIC, click on submit. Will bring up the Eligibility Inquiry Response screen. Scroll down to Coordination of Benefits information. This will show what insurance Medicaid has listed for that client. If the client is deceased or off Medicaid, you may have to place a date along with the client's PIC.

3. http://fortress.wa.gov/dshs/maa/Download/hcarrier.txt

    A. **This site contains all of the Insurance Carriers.** It contains all of the names, addresses and telephone numbers to the insurance carrier codes listed on the coupon under the Insurance column. You will need this resource to identify the insurance and the billing address for claims. The telephone numbers is for verifying eligibility, benefits and claim status.

4. **Insurance Websites**. These individual websites contain eligibility, benefits and claim status.

A. Examples:
www.aetna.com Aetna

https://cingaforhcp.cigna.com/ Cigna
https://www.principal.com/ Principal Financial Group
www.ebmconline.com United Healthcare
https://aarpprovideronlinetool.uhc.com/PROD/pw/index.html AARP

5. **Personal Contact in the Nursing Home Claims Processing Unit**. If your claim is denied for a reason that is not related to insurance, please call your contact in the Nursing Home claims process unit. (see Quick Overview page 2 for contacts)

   A. Please review your DSHS Remittance and Status report denial reason codes before calling Medicaid. An explanation of the denial reason should be contained with the RA.
   B. Please call the correct area for the DSHS denial reason:
      1. If insurance related call Coordination of Benefits
      2. If not insurance related call your contact in the Nursing Home claims processing unit. These questions would involve such things as: class codes, award letters, days, change in participation, days etc.

Section 3

Cost Avoidance **Coupon/Medical ID Card (MAID)**

1. **ALWAYS Check the Coupon/Medical ID Card (MAID) for Insurance.** It is possible that the insurance will change. (cancelled, group went to a different insurance carrier, maxed out).

   Why:
   1. If you are aware that the insurance has moved to a new/different insurance company and the coupon still reflects the old insurance company, please fax a copy of the new insurance card (front and back), a copy of the policy benefits and the client's PIC to: 360-586-3005 Attn: (nursing home case manager)
   2. If the insurance has been cancelled: Call the insurance company, verify the last date of service covered by the policy and get the name of the person you spoke with. Call Coordination of Benefits at 800-562-6136 and give the case manager the last covered date of service and the name of the person at the insurance company. The case manager will update the insurance screen with the cancellation/termination date.

2. A four character alpha-numeric code (insurance carrier code) is listed in the column marked insurance on the coupon/medical ID card (MAID) and you do not know the identity of that insurance:

   Why:
   1. Refer to Section 2 Important Sources of Information numbers 2 and 3 for the Medicaid websites containing client specific insurance information or insurance carrier code information.

3. Only one insurance carrier code will be listed in the insurance column on the coupon/medical ID card (MAID). All other insurance carrier codes will be listed above the client's name and address.

4. If there is an insurance carrier on the coupon/medical ID card (MAID) ask the client/family for a copy of the insurance card and insurance policy.

Why:

1. The card contains all of the identification information, claims billing information, provider toll-free number for eligibility and claims status, possible pre-cert/pre-auth information and how to become an electronic biller. If the client/family does not have a copy of the card, ask that they contact the insurance company and request a card.

Why:

2. Get a copy of the insurance policy. The policy will contain the telephone numbers for pre-cert/pre-auth, how to become an electronic biller and an insurance website. It will also contain the benefits for a stay in a Skilled Nursing Facility. If the client/family does not have a copy of the policy, ask that they contact the insurance company and request a copy.

Why:

3. If the policy indicates, for example: that there is no policy provision for a stay in a skilled nursing facility or perhaps the policy requires a 3 day hospital stay and the client was never in the hospital; fax a copy of the policy, along with the client's PIC and your proposed comment to: 360-586-3005 Attn: (nursing home case manager).

5. If there is no insurance listed on the coupon/medical ID card (MAID) and you are aware that the client does have insurance:

   A. Fax a copy of the insurance card (front and back), a copy of the SNF benefits contained in the policy and the client's PIC to: 360-586-3005 Attn: (nursing home case manager).

Why:

1. You must notify Medicaid if you know of any third-party insurance.

Section 4

Cost Avoidance **Billing Medicaid**

1. **ALWAYS BILL MEDICAID,** even if the client has insurance that will pay.

   Why:
   A. To keep your award letter valid.
   B. Medicaid needs the client's complete history while they are on Public Assistance even if there is a primary insurance.
   C. If you claim is denied to bill the insurance, you have established your timeliness with Medicaid.

      Why:
      1. You want your claim established with Medicaid in case the insurance process takes over a year. Medicaid has a 365 day filing limit from the date of service. If the insurance company denies your claim and it is over the 365 day Medicaid filing limit, Medicaid will not pay unless you have an original internal control number (ICN) that proves you filed your claim within the Medicaid filing limit.
      2. If the insurance company pays and then audits their accounts and determines that they have paid in error and requests the insurance payment be returned, if you have not filed a claim with Medicaid within the year filing limit, Medicaid will deny your claim as not timely.

Section 5

Cost Avoidance **Class Codes**

1. **ALWAYS USE THE CORRECT CLASS CODES.** See page C.1 of the Nursing Facility Billing Instructions.

2. **USE** class 29 or class 24 when the client is in a Medicare stay and is also eligible for Medicaid. **DO NOT** use these class codes for a client who has insurance but is not in a Medicare stay.

   Why:
   1. Class 29 is only to be used for the first 20 days of a Medicare stay (days 1-20) where Medicare is paying the service in full.
   2. Class 24 is only to be used for the next 80 days of a Medicare stay (days 21-100), where Medicare is making a partial payment.

3. Once the client is no longer in a Medicare stay, please change to the appropriate Medicaid class code (see page C.1 of the Nursing Facility Billing Instructions) and indicate if the insurance is paying.

REBILLING MEDICAID WITH INSURANCE PAYMENT FOR CLASS29/24

Your claims will be denied with 032 when class 29/24 is billed to Medicaid reflecting an insurance payment.

032 indicates the insurance payment exceeds the DSHS allowable fee. Your claim will not be paid at zero.

EXCEPTION: If your Medicare rate is very low and the insurance copayment is also very low, DSHS might pay a small amount.

Section 6

Cost Avoidance **Billing Private Insurance**

1. **IMMEDIATELY BILL THE INSURANCE** (even if you know that you will need to bill Medicare for a denial or provide additional information).

   Why:
   1. You will establish a timely claim with the insurance company and keep the Insurance Explanation of Benefits on file for future billings.
   2. If you need a Medicare denial and Medicare does not respond in a timely fashion, your claim will be established with the insurance company.
   3. Not all insurance companies allow 12 months to file a claim, if could be as little as 90 days.
   4. Perform appropriate follow-up with the insurance company in a timely fashion. If you have not heard from the insurance company within a reasonable amount of time, call or access their website to check the status of your claim
      A. You may have to resend information to an insurance company. If possible, get a name and fax number and fax the information to their attention.
      B. You may need to ask to speak with a supervisor.
   5. If your claim is denied by the insurance company as not timely, Medicaid will NOT consider payment. Lack of timely filing with an insurance company is not a valid denial.

2. Bill your private rate.

   Why:
   1. The private insurance is primary to Medicaid, therefore you are not obligated to bill the DSHS rate.
   2. **REMEMBER:** You may only collect the participation from the client. **YOU MAY NOT** charge a Medicaid client for room and board except for the participation.
   3. **YOU MAY** collect the insurance payment from the client/family.
   4. **YOU MAY BE REQUIRED** to refund part or all of the participation after receipt of the insurance payment. (see section 10)

3. Become an electronic biller. It would be to your advantage

Why:

1. This will allow you to submit your claim on-line and receive a response in a more timely fashion.

4. Become a member of the Insurance Company Website. It would be to your advantage.

Why:

1. You can check claim status, benefits and eligibility.

5. Comply with the Insurance Company's request for additional information.

Why:

1. If the requested information (medical record, Medicare denial) is not provided, Medicaid will **NOT** consider payment.
2. If the insurance has a special form and it is not completed, Medicaid will **NOT** consider payment.

6. Call for Pre-cert/Pre-auth/Referral if it is a policy requirement

Why:

1. Medicaid will **NOT** consider payment if you have not completed the pre-cert/-re-auth/referral process.

Section 7

Cost Avoidance **Rebilling Medicaid with an Insurance Denial**

Please remember that the definition of skilled care differs between Medicare, Medicaid and Insurance companies. Medicaid will need something in writing as to why the private insurance will not pay for room and board in a Skilled Nursing Facility.

1. If the insurance denied the room and board with a valid denial reason:

    A. Rebill Medicaid on-line
        1. Place an appropriate comment in the billing comments area as to why the insurance will not cover the room and board.
        2. Rebill a new claim with a clear, precise and valid denial comment.
        3. Fax a copy of your insurance denial back-up documentation to 360-586-3005 Attn: (nursing home case manager). Coordination of Benefits must have something in writing for their files, either a denial from the insurance company or a typed, signed and dated questionnaire from the Skilled Nursing Facility. (see section 8).

    B. Some valid denial reasons (there will be other valid denial reasons that use different wording, but imply the following).
        1. **Non-covered:** explain why it is non-covered, ie: not a covered condition, not medically necessary.
        2. **Policy maxed/maximum benefit paid/maxed per calendar year:** give the date it maxed, how many days per calendar year it covers and when it ended, if it is maxed for a lifetime or if the client can re-qualify if they discharge and re-admit into the SNF.
        3. **Policy not in effect/terminated/cancelled**: call the insurance company, get the termination/cancellation date.
        4. **Elimination period:** give elimination period dates.
        5. **Determined custodial**: explain why it was determined custodial; ie:: per review of medical records, Alzheimer (diagnosis code) care considered custodial.
        6. **Determined not medically necessary.**
        7. **Skilled nursing facility authorization requirements not met.**
        8. **No qualifying hospital stay.**
        9. **100 Medicare days not used.**

    Examples of Appropriate Comments When Billing Medicaid:

        1. Cigna determined not a condition not covered

2. Uniform requires 100 Medicare days used – not used
3. CNA shows 5-1-08 to 6-30-08 as elimination period.

Please make sure you include the name of the insurance company and precise comments that reflect the denial on the insurance Explanation of Benefits.

C. Some invalid denial reasons (there will be other invalid denial reasons that use different wording, but imply the following).

1. Not covered – when a provider calls to see why the service is not covered many times they may find that additional information is required. That is not a valid denial. We need a valid denial reason.
2. Need a Medicare denial
3. Need medical records
4. Additional information required
5. Bill primary carrier
6. Pre-cert/Pre-auth/referral required
7. Claim form needs to be completed
8. Custodial – unless the insurance Explanation of Benefits that is faxed to Medicaid says determined Custodial, we need to know what/how this was determined custodial.
9. Bill type not valid (box 4) on UB92 should not be 210.

If you are unsure what the insurance denial reason means, **PLEASE CONTACT THE INSURANCE COMPANY** for clarification.

D. If the client discharges from the nursing home and admits into the hospital and then readmits into the nursing home, the billing process must be restarted.

Why:

1. The level of care may now meet the insurance company's guidelines for skilled care.
2. Pre-auth/Pre-cert/referral process should be in place for the new admit for a previous client.
3. The policy may go back into effect with a qualifying hospital stay.

Insurance denial codes from Medicaid and how to proceed:

287: The EOB/comment was from an incorrect insurance carrier. Please rebill with correct EOB/comment.

1. Check your template to see what insurance company is noted in your comment.

2. Check WaMedWebHome for the insurance company listed at Medicaid for that client.
3. If you have not sent a denial to Medicaid for the insurance listed with Medicaid, please do so. Your fax will need to contain your new comment.
4. Correct your comment on your template
5. Resubmit a new claim.

288: More than one insurance carrier is available. Please submit EOB/comment for each carrier.

1. Check your template to see what insurance company is noted in your comment.
2. Check WaMedWebHome for the insurance companies listed at Medicaid for that client.
3. If you have not sent a denial to Medicaid for both insurances listed with Medicaid, please do so. Your fax will need to contain your new comment.
4. Correct your comment on you template.
5. Resubmit a new claim.

981: Not a valid insurance denial

1. Please call Medicaid and speak with the nursing home case manager for that specific client.
2. Provide your DSHS provider number, your telephone number with extension, the client's PIC and the date of service.

281: The backup documentation/comments are inappropriate or lacking information. Please rebill with the appropriate information.

1. Please call Medicaid and speak with the nursing home case manager for that specific client.
2. Provider your DSHS provider number, your telephone number with extension, the client's PIC and the date of service.

Section 8

Cost Avoidance **Questions to ask an Insurance Company**

If you do not have an insurance denial on file, a completed questionnaire will need to be faxed to Medicaid at 360-586-3005 Attn: (nursing homecase manager). (see attached example fax)

1. It will need to contain:

   A. Name and signature of person at the Nursing Home calling the insurance company.
   B. Date of call
   C. Name of person at the insurance company
   D. Telephone number of the insurance company
   E. Name of Insurance
   F. Client's name and PIC

2. Questions that will need to be asked:

   A. **What is the benefit for a stay in a skilled nursing facility**: If they say there is none, ask:
      1. "Does the policy cover any Medicare days?" If so, then ask:
      2. "Will the policy pay past the 100th Medicare day?" If so, then ask:
      3. "How many more days will it pay?" Get number of days.
      4. "Does the policy pay a certain number of days per calendar year?" Get number of days.

   B. **If the policy covers skilled nursing facility days**: ask what would be required in order to have a claim adjudicated for possible payment?
      1. Qualifying Hospital stay? If so, how many days?
      2. Must 100 Medicare days be exhausted before the policy would continue to pay?
      3. Pre-authorization? If so, will they retro-authorize?
      4. Pre-certification? If so, will they retro-certify?
      5. Referral? If so, will they accept at retro referral?
      6. Must a provider be an in-network provider? Will they pay an out of network provider?
      7. Medical records/chart notes?
      8. Medicare denial? As proof of medical necessity?
      9. Hospital billing showing proof of hospital stay?

C. **Does the policy require a qualifying hospital stay**: if so, than ask:

Section 8

1. "How many days stay does it require?" (Some policies require more than a 3 day hospital stay.
2. "Would you require a Medicare denial?
3. "Would you require medical records as proof of medical necessity?

D. **Custodial care is not covered**. We need to know **what criteria was used by the insurance** company to determine the care is not skilled. Did you speak with a nurse, a claim specialist, etc. (give us their name and position). Is it custodial because:
    1. Specific diagnosis? If so, give us the diagnosis code and description.
    2. Type of care was determined custodial? If so, clarify the type of care.

E. **Not covered**. Does the Nursing Home need to send additional information to the insurance for review? If so, the service is not denied. We need to know **what criteria was used by the insurance company to determine** the care is not covered. Did you speak with a nurse, a claim specialist, etc. (give us their name and position). Is it not covered because:
    1. Specific diagnosis? If so, give us the diagnosis code and description.
    2. Services were not authorized. Send us proof that the authorization process was completed and the service was not authorized.

If the insurance company representative does not seem to understand what I am trying to ask with the first question, I try to switch it around:

"What is the benefit for room and board in a Skilled Nursing Facility?"

If they do not seem to understand, I will again follow-up with:

"I know that an inpatient stay in a hospital would cover a certain number of days. I am trying to find out how many days would be covered in a Skilled Nursing Home. (I do not want the benefits for skilled nursing hours.)

We will need a fax with this information, date and signed by the Skilled Nursing Facility personal, along with an appropriate comment faxed to: 360-586-3005 Attn: (nursing home case manager). See the attached example fax.

Nursing Facility Name and Provider Number
Address:
Phone Number:
Fax Number:

Example

Fax

To: COB Nursing Facility Case Manager From:

Fax: Pages: 4, including cover sheet

Phone: Date:

Client: Jane Doe, J- 000000 DOE A CC:

Name of Insurance:
Contact person:
Telephone#:

Comments: I re-read the fax from them. The 1st paragraph tells me that they are a co-insurance to Medicare. I then see the part you are looking at stating something about this being a 'traditional plan'. That didn't clearly tell me that they would cover a Skilled Nursing Home stay.

I had asked a member of my team to call and insist on speaking with an actual person to get this cleared up. I had tried twice and failed to find a 'live' person to communicate with. What I found is this:

- This plan can cover after Medicare days are used.
- There must be Pre-Authorization for a stay post Medicare.
- If approved, there will be a case-manager following.

What that tells me is upon admission there was much confusion as to how this benefit worked and in this particular case there indeed was an error on our part. Had we realized this part of the clients benefit better we certainly would have sought pre-authorization to see if the client had met their standard for continued coverage post Medicare.

Jane Doe has been off Medicare since _____. She is not considered to be what Medicare calls 'Benefits Exhaust' (which means that a person is still 'skillable' past day 100), she is considered to be 'custodial' by Medicare standards. I believe it is fair to believe that we are too late for 'post Medicare' coverage. Should they discharge and return the steps will include Medicare first and insurance second then after both are exhausted out then Medicaid would be third.

My comment will read: (name of insurance) requires Medicare 100 days used – not used

Name: _____

Signature: _____

Section 9

Cost Avoidance **Managing Your Insurance Comments**

Providers will manage the client's insurance comments. Once a denial has been received from the insurance company, fax a copy of the denial along with an appropriate comment to: Fax: 360-586-3005 Attn: (nursing home case manager.)**.** Place the comment in your billing comments area and rebill Medicaid with that comment.

1. Place a copy of the comment in the client's file.

   Why:
   1. Providers have lost comments with computer problems.
   2. You will have a record of the comment if there is a change in the client's circumstances.
   3. You will know how the policy functions.

2. Do not use unnecessary comments.

   Why:
   1. No insurance comments are necessary for Medicare supplements plans A thru L unless there is an insurance payment.
   2. No insurance comments are necessary for Medicare replacement plans unless there is an insurance payment.

3. Remove comments if there is a change in circumstance, start of new calendar year and client's policy covers "X" numbers of days per calendar year, client is in their Medicare co-pay days, client has new insurance, etc. Fax: 360-586-3005 Attn: (nursing home case manager)

   Why:
   1. If there is a change in circumstances, Medicaid may need to see a new denial.
   2. If the policy covers "X" number of days, please remove the comment for the covered days and replace a comment for the uncovered days. Example: AARP AD policy 2009 20 days billed 1/1-20/09. Medicaid can start paying from the 21st day on.
   3. If there is a change in insurance, please remove the comment until a denial if faxed to Medicaid.

4. Change a comment if the client is class 29 and the insurance does not cover the first 20 Medicare days. Example: BC Fed will not pay the first 20 Medicare days.

5. Remove the comment when the client is in their Medicare co-pay days and bill the insurance. Once insurance payment is received, rebill Medicaid indicate the insurance paid amount in your comments. Fax a copy of the insurance denial when the insurance ceases paying to: Fax: 360-586-3005 Attn: (nursing home case manager).

Section 10

Cost Avoidance **Rebilling Medicaid with Insurance Payment and Refunding Participation**

1. If the insurance paid for room and board:
    A. Rebill Medicaid on-line:
    B. Indicate in the billing comments field the amount paid by the insurance for the specific dates of service on the billing. Please be very clear and precise, including the name of the insurance company. Examples:
        1. Aetna paid $3456.78
        2. Group Health paid $565.89
        3. CNA paid $550.00 for 5/21-31/08 elimination period ended 5-20-08
    C. If your comments are not clear, your claim will be denied to clarify your comment.
    D. If our records indicate conflicting information, you claim will be denied until the conflict is resolved.
    E. Please do not adjust a denied claim, always re-bill a new claim. If the date of service is over 365 days, please reference the original internal control number (ICN) in your remarks.
    F. If the insurance payment is equal to or greater than the Mediciaid maximum allowable rate, the claim has been paid in full. You do not need to re-bill.

2. Since the insurance company was billed the Skilled Nursing Facility private rate, it is possible that you will need to refund part/all of the participation and report that refund to the Home and Community Service Office (HCS). [WAC 388-96-803 see attached]

3. HOW TO DETERMINE EXCESS

These examples will be using the private rate when billing the insurance company.

Example:

If the private rate is $200.00 per day for a 30 day month the billed amount would be $6000.00.

If the Medicaid rate for the same month was $150.00 per day for a 30 day month the HRSA billed amount would be $4500.00.

Section 10

If the client participation is $1500.00 per month, the nursing home would collect the client participation of $1500.00 and bill the insurance company the private rate of $200.00 per day.

First Example:

$6000.00 private rate billed to insurance company

$2000.00 is paid by the insurance company

Take the:

$4500.00 Medicaid rate Minus
$2000.00 amount paid by insurance company Leaves

$2500.00 still due for the client's care Minus
$1500.00 client participation for the month Leaves

$1000.00 will need to be re-billed to Medicaid. There is no excess to refund and report.

Second Example:

$6000.00 private rate billed to insurance company
$3500.00 paid by insurance company

Take the:

$4500.00 Medicaid rate Minus
$3500.00 amount paid by insurance company Leaves

$1000.00 still due for the client's care Minus
$1500.00 client participation for the month Leaves

$500.00 of the client participation needs to be refunded to the client and reported to the HCS office per attached WAC. Do not re-bill Medicaid

Third Example:

$6000.00 private rate billed to the insurance company
$4500.00 paid by the insurance company

Take the:

$4500.00 Medicaid rate Minus
$4500.00 amount paid by insurance company Leaves

$0 due for the client's care Minus
$1500.00 client participation for the month Leave

$1500.00 of client participation needs to be refund to the client and reported to the HCS office per attached WAC. Do no re-bill Medicaid.

REMEMBER: If the insurance payment is the same as the Medicaid billed amount or greater than the Medicaid billed amount, the full participation must be refunded to the client and reported to the Home and Community Service office as a change in circumstance.

Fourth Example:

$6000.00 private rate billed to the insurance company
$5500.00 paid by the insurance company Leaves

$1000.00 paid by the insurance company over the Medicaid rate and the client paid

$1500.00 in participation. That participation will need to be refunded to the client and reported to the Home and Community Service office per attached WAC. Do no re-bill Medicaid.

Do not refund $2500.00 ($1000.00 additional paid by the insurance company plus $1500.00 participation), you are only concerned with repaying the client's participation amount. The nursing home may keep the $1000.00 over the Medicaid rate.

Section 10

REMEMBER: If the insurance payment is the same as the Medicaid billed amount or greater than the Medicaid billed amount, the full participation must be refunded to the client and reported to the Home and Community Service office.

If the insurance payment is less than the Medicaid rate, part or none of the participation would need to be refunded and reported to the Home and Community Service office.

Chapter 388-96-803 WAC – The Washington State Legislature

TITLES >> WAC 388 TITLE >> WAC 388 – 96 CHAPTER

WAC 388-96-803 When a nursing facility (NF) contractor becomes aware of a change in the Medicaid resident's Income and/or resources, must he or she report it? Yes, within seventy-two hours of becoming aware of a change in the Medicaid resident's income and/or resources, the NF contractor will report the change in writing to the home and community services office serving the area in which the NF is located. When reporting the change, the NF contractor will Include copies of any available documentation of the change in the Medicaid resident's income and/or resources.

[Statutory Authority: RCW 74.46.800 01-12-037 388-96-803, filed 5/29/01, effective 6/29/01]

ADSA Cost Avoidance Transition

Frequently Asked Questions

And

Home and Community Service

Good Cause Policy

COST AVOIDANCE TRANSITION
Frequently Asked Questions
Revised December 2008

1. Why is this change occurring?

Cost avoidance (Medicaid payment only after establishment and reduction of all third party liability) has always been a regulatory requirement of coordinating benefits for payment of Medicaid services. Exceptions, or waivers, for some services, primarily pharmacy, were previously granted to some states. For the past five years, pharmacies in Washington State have been performing their own cost avoidance. Our nursing home waiver expired last year. CMS has allowed us to make the transition to cost avoidance for nursing homes claims complete by January 1, 2007.

2. Will we be reimbursed for extra staff needed to implement these changes?

Only to the extent that the current nursing home rate methodology recognizes these expenses will you be reimbursed. There is a strong likelihood that for some residents you will receive more money from insurance carriers than the department pays in the form of Medicaid payments so much, if not all, of this cost will be absorbed that way.

3. During the time that we are awaiting approval or denial from the insurance company, will we receive any Medicaid reimbursement?

You will not receive immediate payment for residents with third party coverage. Medicaid will only pay for such residents who ultimately are found to have received payment at less than the Medicaid rate or a valid denial of coverage by the insurance carrier. All others will be paid in full by the insurance carrier.

4. During the period we are awaiting approval or denial from the insurance company, are the residents to be considered "Medicaid residents"?

Yes. The clients have already been determined to be eligible for Medicaid. The only question is whether or not there is a third party that should pay before the department does so that Medicaid is truly the payer of last resort.

5. If we go thirty days without reimbursement from the insurance company can we discharge the resident for non-payment? If not, why not?

Federal rules only allow discharge of a Medicaid resident when the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Lack of payment would have to be due to non-cooperation of the resident. You must also provide adequate advance notice,

fair hearing rights and meet other discharge requirements as per this same federal regulation (42 CFR 483).

6. On average how long do you expect reimbursement approval or denial from the insurance company to take?

That will depend on the insurance carrier. The department has no control over the private insurance industry and the nursing homes will need adequate documentation to support any claim. It will be incumbent upon the nursing homes to submit to the insurance carrier enough documentation to support their claim so that payment will not be delayed for lack of documentation. The nursing home should treat the Medicaid resident the same as a private pay resident. This will meet the payer of last resort requirement for Medicaid.

7. How will we know if the individual has insurance?

The award letters for residents who are currently in the nursing home may indicate whether there is another source of payment for the resident. For other Medicaid residents you will need to ask the resident and family members at the time of admission if they know about insurance. If it is not stated on the award letter, report it promptly to the department. The department will also provide this information on the MAID card.

8. What do we do if the family refuses to turn the insurance check over to the nursing home? If the family decides to keep the check, can we discharge the resident?

The nursing home should first contact the family to make sure they understand their obligation. If the family continues to keep insurance money that is meant to cover the cost of care of a Medicaid resident, the nursing home should pursue with the resident and the insurance company the possibility of the insurance company sending the funds directly to the nursing home. If the resident refuses to cooperate, that may result in the NH considering discharge for non-payment, subject to the limitations as noted in No. 5 above. If the resident lacks capacity (i.e., family is handling the money as legal guardian or power of attorney) then the nursing home may refer the situation to Adult Protective Services. Another possibility is that the NH can file a petition for guardianship for the resident.

9. Once a carrier has denied payment and there is no change in circumstances (discharge and readmission, hospital stay or other change in the resident's condition, etc.) do I have to continue to bill the carrier and wait for duplicate denials before subsequent Medicaid payments will be made?

Once a valid denial is received and forwarded to Medicaid, you will not be required to bill for duplicate denials unless there is a change in circumstances. Please see the section in the COB Cost Avoidance Suggestions and Helpful Hints packet for rebilling Medicaid with a valid denial.

10. Who is our primary contact at DSHS if we have questions concerning this process?

If you have question regarding cost avoidance, you may call Toll-Free 1-800-562-6136 as for the nursing home case manager and give the client's last name.

11. Do I have to send in a paper copy of the Insurance Explanation of Benefits denial when I rebill Medicaid?

A copy of the denial will need to be faxed along with your comment to: 360-586-3005 Attn: Nursing home case manager. Once the case manager has a copy of the denial and it is determined to be valid, you will no longer need to send a paper denial unless there is a change in circumstance.

12. Do I adjust my claim or submit a new claim when rebilling Medicaid with an insurance denial or insurance payment?

If your claim was denied, always submit a new claim. See page L.1 of the General Information Booklet for information concerning the correct process for rebilling Medicaid. The General Information Booklet can be found under Billing Instructions/Numbered Memoranda on the web site.

13. Should I bill my private rate to the insurance company?

Yes. DO NOT bill the participation or reflect the participation on your claim. You are entitled to the primary insurance's contracted allowed amount for room and board.

14. Should I use 210 in box 4 type of bill on the UB92 when billing the private insurance?

No. Do not use 210 when billing for the private insurance. Please use the appropriate bill type which would be: 211, 212, 213, 214, etc.

15. Can I place a comment in the comments area of the UB92 when billing the private insurance?

DO NOT put comments such as: Care is custodial/not skilled or billed per Washington State Medicaid. It is up to the insurance company to determine if the care meets their guidelines for skilled or custodial care. Since the insurance company is primary to Medicaid, DSHS is not involved until after the insurance company has made a determination.

16. Do I place a dollar amount on the UB92 in box 48, non-covered services?

No. DO NOT place any dollar amount in box 48. The insurance company must determine if any of the services are covered.

17. Why did Medicaid deny my claim after the insurance company denied it for non-network/non-participating/non-contracted provider?

When the insurance information is reflected on the MAID, Medicaid normally does not pay for services performed out of network. See question No. 18.

18. What do we do if we discover a resident has insurance but we are not a network/participation/contracted provider for their insurance?

See the attached Home and Community Services Private Health Insurance and Good Cause Determinations.

Home and Community Services Private Health Insurance and Good Cause Determinations

Medicaid clients are required to cooperate in the identification and use of third party liability (insurance carriers) that may be responsible for paying for nursing facility care and other long-term care services. Clients may object to the options offered by their private insurance for a variety of reasons, including the location of the facility. The Department is allowed to exempt the client from cooperation if we have determined that there is "good cause" for the exemption.

If a client has third party liability (TPL) and resides in a facility that is a non-participation/non-network/non-contracted provider of the plan the following process will occur:

1. The nursing facility will contact the insurance carrier to determine if they will pay an non-participation/non-network/non-contracted provider, or can decided to become a participation/network/contracted provider is possible.
2. In coordination with HCS the nursing facility can determine if a client could be exempted from using their TPL is there is no DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes from the client's current residence.
3. If there is a DSHS participating/network/contracted nursing facility within 25 miles or 45 minutes of the client's current residence, the NFCM will talk with the client and/or their representative about the possibility of moving to a facility that is in the insurance carrier's network.
4. The department will determine if good cause exists.

To determine good cause the NFCM will evaluate the reasons why the client does not want to transfer to a participating network provider. Good cause can include a variety of reasons such as location, physical or emotional harm, or a move to a different NF will case transfer trauma. If the client is deceased, no longer a resident at the facility, or no longer has the insurance a local exception to policy to WAC 388-501-0200 may be submitted.

The Regional Administrator or their designee will make the final decision regarding good cause determinations. The NFCM will document in SER if good cause is approved or denied and inform HRSA-Cover of Benefits (nursing home desk) of the outcome. To

contact the nursing home desk call the following number and extension based on the client's last name:

1-800-562-6136
A – G extension 51936
H – Z extension 51164